

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025732

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6979

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

FILED JUL 12 1963

1. PLACE OF DEATH
a. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN ST. LOUISLength of stay in 1b
40 yrs.2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTYc. CITY
OR
TOWN ST. LOUISInside Limits
Yes ☐ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION 4008a ENRIGHTInside Limits
Yes ☐ No ☐d. STREET
ADDRESS (If outside, give location)
4008a ENRIGHTReside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)First
GUSSIE

Middle

Last
CARTER4. DATE
OF
DEATHMonth
JULY

Day

Year

1, 1963

5. SEX

Female

6. COLOR OR RACE

Negro

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

4/20/98

9. AGE (last birthday)

65

IF UNDER 1 YEAR

Months Days Hours Min.

2 11

IF UNDER 24 HR.

Hours Min.

2 11

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Seamstress

10b. KIND OF BUSINESS OR INDUSTRY

Self-employed

11. BIRTHPLACE (City and state or country)

Louisville, Ky.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Unknown

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

LOUIS CARTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of serv)

No

17. INFORMANT

Address

Frances Carter, 4649 Cote Brill.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Diabetes Mellitus

DUE TO (b)

Chronic Myocarditis

DUE TO (c)

260X

INTERVAL BETWEEN
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

to

and last saw her
him alive on

Death occurred at 7:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREATION,
REMOVAL (Specify)

Removal

23b. DATE

7/6/63

23c. NAME OF CEMETERY OR CREMATORY

Washington Park Cem.

23d. LOCATION (City, town, or county)

St. Louis County, Mo.

24. FUNERAL DIRECTOR

ADDRESS

CHARLES J. GATES, JR., 4107 Finney

25. DATE RECD. BY LOCAL REG.

JUL 5 1963

26. REGISTRAR'S SIGNATURE

Road Smith, H.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

DATE AMENDED

VS 300
Rev. 4/59

1

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-1290-3

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Graydon Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.